My name is Kathy Cashin and I am an ICU nurse at St Vincent's Hospital. I have been an ICU nurse for many years. I would like to focus my testimony on three specific points, knowing that other nurses will be speaking and submitting written testimony on other aspects of these proposed regulations.

First, I would like to focus on the **makeup of the committees at each hospital who will work to create and approve the acuity tool (or tools) to be used at that particular hospital**. **It is extremely important that the acuity tools chosen are specifically designed to meet the needs of each hospital**- as some hospitals have general ICU, while others have multiple, specialized ICUs. This will not be a case where "one size fits all" across all hospitals and all types of ICUs. The needs of an ICU like mine, a Critical Care Unit which cares for medical, surgical, cardiac and cardio-thoracic patients will be different from the needs of a burn-specific ICU or a NICU. To do this, the committees at each hospital must include at least 50% direct care ICU registered nurses (RNs) and these nurses must reflect the needs of that specific ICU. For example, not all of the RNs are educated to care for all patients that come into our units. There are universalist RNs who are prepared to care for any and all patients who enter those doors. Then there are RNs who are not experienced at caring for some specific patients, for example Cardio-Thoracic patients or cardiac patients who have Intra-Aortic Balloon Pumps in them. We work this out in the unit among ourselves when caring for our patients- if a cardio-thoracic patient is admitted, we know which nurse has the most experience with this type of patient- but it is important that the RNs caring for all type of patients are on the committee to choose an acuity tool for 1:1 Nursing Care. They understand when 1:1 care is necessary and of the utmost importance to deliver the high standard of care we all strive to provide to our patients in their most vulnerable critical condition. And **I cannot stress enough the importance of this committee- which must be comprised of at least 50% direct care ICU nurses - having the ultimate authority to accept or reject any tool.** Hospital management must not be allowed the opportunity to override this decision. If not, all of the work that we have done in passing this law and all the work that you have done in drafting these regulations will have been for nothing and we will be right back where we were- hospital management, not the nurses, making decisions for our patients and putting them at risk.

The second point I would like to make is about **the importance of requiring more frequent assessments of the ICU patients**. I believe, at a minimum, that the regulations should require the assessments to be performed by the nurses every four hours and as necessary due to changes observed in the patients. Right now, the draft regulations call for a patient's stability to be assessed upon admission, once as shift and "at other intervals". This is not appropriate. Let me provide you with some examples of why the regulations must require more frequent assessments. A stable post op Cardiothoracic patient may become unstable after warming them up. Now the patient requires the frequent titratration of their vasopressors. The patient may require minute to minute titrations on those drugs due to the fluctuation of their blood pressure going from

hypotension to hyper- tension and then when they are able to turn from side to side, their chest tube drainage may increase and may require giving multiple blood products in addition to titrating their drips and obtaining frequent bloodwork. The patient may need preparing to return to the OR if the bleeding cannot be controlled with all of these other measures. And all of these changes can happen quickly. A Cardiothoracic patient may be in one place at the beginning of a shift and a completely different place at the end of the shift- with variations in between. Another example is a stable septic patient who comes up from the ER- then all of a sudden their blood pressure drops to dangerously low numbers requiring vasopressors which in turn require central lines to infuse and the patient only has peripheral lines, so now we have a situation in which we need the Surgical PA or NP to place the line for the medical doctor and they may or may not be teaching them how to place the line. Also if the patient was not intubated at the time of admission, then they may need to be intubated for airway protection or to prevent a respiratory arrest. So now we are very far away from the "stable" septic patient that presented just an hour ago.

The third and final point I would like to make is related to **hospitals staffing to a default two patients to one nurse standard- a violation of the law.** A stable gastrointestinal (GI) bleed patient may all of a sudden start bleeding and require blood products and may require a Scope done at the bedside. This may show an active bleed or not. In either case, the patient may re-bleed and require a Red Tag Scan in which the patient's RN might have to go to Interventional Radiology for a procedure to be done there to attempt to stop the bleeding. This may take several hours and if that RN had a second patient, he or she would not be able to see that patient and care for them and it would fall to the other RNs in the unit. If each of these nurses already has their own two patients, because the hospital has not staffed appropriately for one to one assignments, the second patient of the first RN who had to travel with her formerly "stable" patient will be tripled- a clear violation of the law and an unsafe situation for all three patients. This is what will happen if you are not clear in your regulations that a one nurse to one patient assignment is the standard.

I urge you to remember that these are people's lives. It matters what you write in these regulations. It matters that the people selecting the tool have the expertise necessary and it matters that their decisions are not allowed to be overridden. It matters that the regulations require frequent assessments of the patients. It matters that you explicitly tell the hospitals that they must default to a one to one nurse to patient assignment.

Thank you.